Washington State Department of Social & Health Services
ADSA Aging & Disability Services Administration

NURSING SERVICES REFERRAL

1. REFERRED TO	2. DSHS OFFICE	DATE OF REFERRAL
3. CLIENT NAME (LAST, FIRST, MI)		
DATE OF BIRTH	TELEPHONE NUMBER	CLIENT ID NUMBER
4. CLIENT MAILING ADDRESS	CITY	STATE ZIP CODE
5. CAREGIVER NAME (LAST, FIRST, MI)	6. AGENCY NAME (IF AGENCY CAREGIVER)	TELEPHONE NUMBER
7. CONTACT NAME (IF DIFFERENT THAN CAREGIVER)		TELEPHONE NUMBER
8. CONTACT RELATIONSHIP TO CLIENT	9. GUARDIAN NAME (IF ANY)	TELEPHONE NUMBER

10. REFERRAL REQUEST

10. Requested Activity (check all that apply) — **11. Activity Frequency (days/week times per week/month/year)**

☐ Nursing Assessment/Reassessment (visit)	Frequency Duration of Activity:
☐ Instruction to client and/or Providers (visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (with visit)	Frequency Duration of Activity:
☐ Care and health resource coordination (without visit)	Frequency Duration of Activity:
☐ Evaluation of health related elements of assessment Or service plan (without visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (with visit)	Frequency Duration of Activity:
☐ Skin Observation Protocol (without visit)	Frequency Duration of Activity:

12. REASON FOR REQUEST (Check all that apply)

☐ Unstable/potentially unstable diagnosis	☐ Immobility issues affecting plan of care
☐ Caregiver training required per CARE Assessment	☐ Current or potential skin problem (not SOP)
☐ Medication regimen affecting plan of care	☐ Skin Observation Protocol
☐ Nutritional status affecting plan of care	☐ Other reason:

13. SPECIAL INSTRUCTIONS

☐ Requesting visit be made with case manager
☐ Consult with case manager before contacting client or caregiver
☐ Request visit with Caregiver
☐ Additional Comments:

14. SW/CASE/RESOURCE MANAGER	E-MAIL ADDRESS	FAX NUMBER
CASE/RESOURCE MANAGER TELEPHONE NUMBER or 1-800-		DATE

IMPORTANT: Please be sure to Fax current CARE Assessment if the nursing resource does not have access to CARE

Confirmation of Receipt and Acceptance of referral by Nursing Services Provider

☐ Referral received Date Received:
☐ Referral accepted
☐ Referral not accepted
☐ Nurse Assigned:
Telephone Number:
☐ Additional Comments:

Instructions for Completing Nursing Services Referral

The Nursing Services Referral is completed for initiation of a referral to Nursing Services provided for Division of Developmental Disability or Children's Administration clients. This form is completed by the case manager and sent to the contracted Nursing Services provider (Area Agency on Aging, contracted agency or contracted individual RN). This form should be completed each time a new referral request for nursing services is being established for a client.

1. **Referred To:** Enter the name of the Area Agency on Aging, contracted agency or contracted Nurse Consultant.

2. **DSHS Office:** Enter the name of the Division of Developmental Disabilities or Children's Administration office.

3. **Client Name:** Enter the client's name, date of birth, telephone number and client ID number (ACES ID).

4. **Client Address:** Enter the address where the client is residing, and would receive services.

5. **Caregiver Name:** Enter the caregiver name. If the client has multiple caregivers, enter the name of the primary caregiver for the client. Enter the telephone number of the caregiver.

6. **Agency Name:** Enter the name of the Home Care Agency as needed. Enter the telephone number of the Home Care Agency.

7. **Contact Name:** Enter any contact name information if different than the caregiver.

8. **Contact Relationship to Client:** Enter the relationship of the contact name to the client (e.g. parent, sibling, friend).

9. **Guardian Name and Telephone Number:** Enter the guardian name and telephone number as appropriate.

10. **Referral Request:** The case manager checks all of the nursing services requested for the client, indicating the type of activity and whether a visit is requested with that activity. (ADSA Chapter 24 LTC Manual).

11. **Requested Activity Frequency:** Enter the frequency and duration of the activity requested (e.g. once a month for six months, once a week for two weeks, one time only).

12. **Reason for Request:** Enter the Nursing Referral Indicator(s) or other reason the client is being referred for Nursing Services.

13. **Special Instructions:** Enter any special instructions for this Nursing Services referral. This includes contacts to be made prior to the activity, whether a joint home visit needs to be made, and any other additional comments.

14. **SW/Case Resource Manager:** The referrer completes this information with the case manager name and contact information.

Confirmation of Receipt and Acceptance of Referral by Nursing Services Provider

The receiving Nursing Services provider completes the section to indicate to the referral source the receipt and acceptance of the referral to provide the requested nursing activity. The referral form is sent back to the referral source with the following information completed within two working days.

Referral Received: Enter the date the referral was received.

Referral Accepted: Check this box if the referral is accepted and the provider is able to provide the requested nursing services activities.

Referral Not Accepted: Check this box if the referral is not able to be accepted, and the provider is unable to provide the requested activities.

Nurse Assigned: Enter the name of the nurse and contact information (telephone, office and e-mail as needed).

Additional Comments: The Provider enters any additional comments needed for the referent.